DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 0 0 — 0 2 4

2. STATE: Minnesota

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
August 1, 2000

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
Section 1833(t) of the Act

7. FEDERAL BUDGET IMPACT:
a. FFY '00 $ 858
b. FFY '01 $ 5,111

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Preprint pages 83b-83d
Att. 4.19-B, pp. 1-1c; 3-3b; 18

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Preprint page 83b
Att. 4.19-B, pp. 1-1c; 3-3a; 18

10. SUBJECT OF AMENDMENT:
Rates: Outpatient Hospital and Freestanding Ambulatory Surgical Center Services

11. GOVERNOR'S REVIEW *(Check One)*:

☒ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:
Mary B. Kennedy

14. TITLE:
Medicaid Director

15. DATE SUBMITTED:
September 28, 2000

16. RETURN TO:
Stephanie Schwartz
Minnesota Department of Human Services
444 Lafayette Road North
St. Paul, Minnesota 55155-3853

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 9/29/00

18. DATE APPROVED: 11/3/00

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
August 1, 2000

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:
Cheryl A. Harris

22. TITLE: Associate Regional Administrator
Division of Medicaid and Children's Health

23. REMARKS:

RECEIVED
SEP 29 2000
DMO - Mn/Wi

FORM HCFA-179 (07-92)

Instructions on Back

MINNESOTA

MEDICAL ASSISTANCE

Federal Budget Impact of Proposed State Plan Amendment TN 00-24

Attachment 4.19-B: Rates and Outpatient Prospective Payment System

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Medicaid outpatient hospital facility services are paid according to Medicare rate methodology. For these services, proposed State plan amendment TN 00-24 amends Minnesota's Medicaid rate methodology to follow §1833(t) of the Social Security Act. That section requires specific outpatient hospital services to be paid pursuant to the prospective Ambulatory Payment Classification (APC) system. Section 1833(t) was added to Title XVIII by the Balanced Budget Act of 1997 (P.L. 105-33) and amended by the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (P.L. 106-113).

Effective August 1, 2000, Minnesota will pay outpatient hospital facility claims in accordance with the most recent APC system rates published in the Federal Register, listed in the column marked "Payment Rate." These are the rates prior to wage adjustments, outlier adjustments, conversion factoring, transitional pass-through payments, or transitional corridor payments.

State Plan Changes

1. As the Department has discussed with HCFA, we anticipate processing outpatient hospital facility and freestanding ambulatory surgical center claims in February, 2001, for services provided on or after August 1, 2000. Until the time the Department is able to process claims, providers will be paid on an interim basis, with settle-up to follow. At the direction of HCFA, preprint pages 83b-83d are submitted to allow for federal financial participation for the interim payments based on projected provider claims and the settle-up payments based on actual claims.

2. Page 1c: Ambulatory surgical center (ASC) facilities are paid according to the methodology for the technical component of the surgical procedure in item 2.a., Outpatient hospital services. The reference to item 2.a. is not a change in current policy, which is that ASC facilities are paid for surgical procedures pursuant to the same methodology that provider-based outpatient hospital facilities are paid.

3. Pages 3-3b: Deletion of language in Attachment 4.19-B, item 2.a. governing emergency room operating charges and miscellaneous outpatient hospital facility component charges is made in advance of the effective date of regulations governing use of national coding pursuant to the Health Insurance Portability and Accountability Act of 1996, (P.L. 104-191). When the HIPAA regulations are effective, no Minnesota-specific codes will be accepted for outpatient hospital facility services.

4. Page 18: Language clarifies that freestanding ASCs are not paid pursuant to the APC system.

No public notice was required to be published pursuant to 42 CFR §447.205(b)(1) (change is made to conform to Medicare methods or levels of payment).

The State estimates the fiscal impact of the changes as follows:

	FFY '00*	FFY '01
TOTAL Medicaid Cost	$1,666,666	$10,000,000
State cost	808,666	4,889,000
Federal cost	**858,000**	**5,111,000**

* August-September, 2000

State MINNESOTA

Citation 6.1 Fiscal Policies and Accountability

9. The State agrees that this policy applies only to payments based on projected provider claims made because **State** Y2K claims processing problems preclude the State from processing and paying provider claims in accordance with normal program claiming requirements. It does **not** apply to payments made because of Y2K problems which preclude providers from billing the State, or because of problems not related to State Y2K claims processing problems. State payments based on projected provider claims that are not in accordance with all of the terms and conditions of this State plan amendment will be disallowed.

10. Before implementation, the State must submit to the Regional Office for approval, along with this state plan amendment, the State's plan for specifically implementing the terms and conditions of this State plan amendment.

Federal Matching of Ambulatory Payment Classification (APC) System Payments to Medicaid Outpatient Hospital Facility Providers

Given the desire to avoid disruptions of services to recipients, while also ensuring the ongoing fiscal integrity of the Medicaid program, HCFA will provide FFP in Minnesota's interim payments based on projected provider claims made in accordance with all of the following terms and conditions during the period August 1, 2000 through April 30, 2001 that are a direct result of State claims processing issues.

1. FFP is available for bimonthly interim payments based on projected provider claims during the period August 1, 2000 through April 30, 2001, that are the direct result of State claims processing issues. If the State's claims processing system processes APC claims before April 30, 2001, FFP will no longer be available for any projected payments made after the date the State's claims processing system processes APC claims.

2. The projected provider claims for which FFP will be available are computed by the State as the average payment to providers that received an average of at least $2000 on each paid warrant claim for the period November 1, 1999 through April 30, 2000.

State MINNESOTA

Citation 6.1 Fiscal Policies and Accountability

A. Providers that received an average of at least $2000 on each paid warrant claim for this time period were offered interim payments. All providers in this group chose to receive interim payments.

B. Providers that received an average less than $2000 on each paid warrant claim for this time period were given the opportunity to request interim payments. No providers in this group chose to receive interim payments.

3. Once the State determines the bimonthly interim payment to the provider, HCFA will allow the State to claim FFP for the projected payments.

4. The State is making and tracking payments within its MMIS system for which FFP was claimed based on projected provider claims.

5. When the period for which FFP is available for bimonthly interim payments based on projected provider claims ends, the State must incorporate into its claims processing system an edit check designed to preclude duplicate payments to providers where payments based on projected provider claims were made and have not yet been fully reconciled.

6. By no later than May 1, 2001, for each provider, the State must begin reconciling payment made based on projected provider claims accounts receivable balances for the August 1, 2000 - April 30, 2001 period against a three-month average warrant paid during that same period. Out of all paid claims, any amount over the established three-month average warrant paid will be applied to the credit/recoupment balance owing. All overpayments that were made based on projected provider claims must be returned as overpayments **by March 31, 2002.** No FFP will be available for extended repayment schedules for providers.

7. Before implementing this interim payment process, the State must purge its files of all excluded providers to preclude any payments to excluded providers.

State MINNESOTA

Citation 6.1 Fiscal Policies and Accountability

8. Once the State has completed the final reconciliation of all accounts receivable balances, the State must report the Federal share of any outstanding State overpayments to HCFA on the next Form HCFA-64. **Any outstanding overpayments that have not been reported on the Form HCFA-64 for the quarter ending March 31, 2002 will be disallowed.**

9. The State agrees that this policy applies only to payments based on projected provider claims made because temporary State claims processing issues preclude the State from processing and paying provider claims in accordance with the APC system. It does not apply to payments made because of problems that preclude providers from billing the State, or because of issues not related to State claims processing issues. State payments based on projected provider claims that are not in accordance with all of the terms and conditions of this State plan amendment will be disallowed.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
Other Types of Care

The following is a description of the policy and methods used in establishing payment rates for each type of care and services included in the State plan.

Medical Assistance payment for Medicare crossover claims is equal to the Medicare co-insurance and deductible.

IHS/638 Facilities: Except for child welfare-targeted case management services, services provided by facilities of the Indian Health Service (which include, at the option of a tribe, facilities owned or operated by a tribe or tribal organization, and funded by Title I or III of the Indian Self-Determination and Education Assistance Act, P.L. 93-638, as amended, operating as 638 facilities) are paid at the rates negotiated between the Indian Health Service and the Health Care Financing Administration and published by the Indian Health Service in the Federal Register. Child-welfare targeted case management services are paid in accordance with the methodology in item 19.b., child welfare-targeted case management services.

Outpatient services provided by facilities defined in state law as critical access hospitals (and certified as such by the Health Care Financing Administration) are paid on a cost-based payment system based on the cost-finding methods and allowable costs of Medicare.

Except in the case of critical access hospitals, for obstetric care the base rate is adjusted as follows:

- outpatient hospital obstetric care (as defined by the Department) technical component (provided by outpatient hospital facilities) receives a 10% increase over the base rate.

- all other obstetric care (as defined by the Department) receives a 26.5% increase over the base rate.

Pediatric care (as defined by the Department), except for the technical component provided by an outpatient hospital facility, receives a 15% increase over the base rate.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
Other Types of Care (continued)

Legislation governing maximum payment rates sets the calendar year at 1989, except that the calendar year for item 7, home health services, is set at 1982. Rates for services provided by community and public health clinics are increased by 20%, except for laboratory services.

Exceptions to the 50th percentile of the submitted charges occur in the following situations:

(1) There were less than 5 billings in the calendar year specified in legislation governing maximum payment rates;
(2) The service was not available in the calendar year specified in legislation governing maximum payment rates;
(3) The payment amount is the result of a provider appeal;
(4) The procedure code description has changed since the calendar year specified in the legislation governing maximum payment rates, therefore, the prevailing charge information reflects the same code but a different procedure description;
(5) The 50th percentile reflects a payment which is inequitable when compared with payment rates for procedures or services which are substantially similar or when compared with payment rates for procedure codes or different levels of complexity in the same or substantially similar category; or
(6) The procedure code is for an unlisted service.

In these instances, the following methodology is used to reconstruct a rate comparable to the 50th percentile of charges submitted in the calendar year specified in legislation governing maximum payment rates:

(1) Refer to information which exists for the first four billings in the calendar year specified in legislation governing maximum payment rates; and/or
(2) Refer to surrounding and/or comparable procedure codes; and/or
(3) Refer to the 50th percentile of years subsequent to the calendar year specified in legislation governing maximum payment rates; and "backdown" the amount by applying an appropriate CPI formula. The CPI formula is updated July 1 of each year to incorporate the current year's CPI; and/or
(4) Refer to relative value indexes; and/or
(5) Refer to payment information from other third parties, such as Medicare; and/or
(6) Refer to a previous rate and add the aggregate increase to the previous rate; and/or

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
Other Types of Care (continued)

(7) Refer to the submitted charge and "backdown" the charge by the CPI formula. The CPI formula is updated July 1 of each year to incorporate the current year's CPI.

If a procedure was authorized and approved prior to a reference file rate change, the approved authorized payment rate may be paid rather than the new reference file allowable.

HCPCS MODIFIERS

Medical Assistance pays more than the reference file allowable in the following areas:

20 microsurgery = 35% additional reimbursement.

22 unusual procedural services = additional reimbursement based on line description or claim attachment. This modifier specifies a ratio for twin delivery and VBAC delivery. All other services are priced according to the service rendered.

99 multiple modifier = may be an increase or a decrease to the reference file allowable depending on the modifiers represented within the 99.

In accordance with Minnesota Statutes, §256B.37, subdivision 5a:

No Medical Assistance payment will be made when either covered charges are paid in full by a third party payer or the provider has an agreement with a third party payer to accept payment for less than charges as payment in full.

Payment for patients that are simultaneously covered by Medical Assistance and a liable third party other than Medicare will be made as the lesser of the following:

(1) the patient liability according to the provider/third party payer (insurer) agreement;

(2) covered charges minus the third party payment amount; or

(3) the Medical Assistance rate minus the third party payment amount.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
Other Types of Care (continued)

IHS/638 FACILITIES:

An encounter for a 638 or IHS facility means a face-to-face encounter/visit between a recipient eligible for Medical Assistance and any health professional at or through an IHS or 638 service location for the provision of Title XIX covered services in or through an IHS or 638 facility within a 24-hour period ending at midnight. Encounters/visits with more than one health professional and multiple encounters/visits with the same professional, within the same service category, that take place in the same 24-hour period, constitute a single encounter/visit, except when the recipient after the first encounter/visit suffers an illness or injury requiring additional diagnosis or treatment. Service categories for IHS/638 facilities are: ambulance, chemical dependency, dental, home health, medical, mental health, and pharmacy.

Services included in the outpatient rate include:

- outpatient hospital ambulatory surgical services
- outpatient physician services
- outpatient dental services
- pharmacy services
- home health agency/visiting nurse services
- outpatient chemical dependency services
- transportation services if the recipient is not admitted to an inpatient hospital within 24 hours of the ambulance trip

Services included in the inpatient rate include:

- inpatient hospital services
- transportation services if the recipient is admitted to an inpatient hospital within 24 hours of the ambulance trip

Inpatient physician services are paid in accordance with the methodology described in item 5.a., Physicians' services.

The ambulatory surgical center facility fee is paid in accordance with the methodology for the technical component of the surgical procedure described in item ~~6.d.C., Ambulatory surgical centers~~ 2.a., Outpatient hospital services.

2.a. Outpatient hospital services.

Payments for outpatient hospital services may not exceed in aggregate the total payments that would have been paid under Medicare.

Outpatient hospital facility services are paid ~~as follows:~~ in accordance with the most recent Ambulatory Payment Classification system rates published by the Health Care Financing Administration in the Federal Register, listed in the column marked "Payment Rate," except that

~~**Emergency room operating charges** are paid the lower of:~~

~~(1) submitted charge; or~~

~~(2) 114.04% of the 1990 average submitted charge:~~
~~a) Anesthesia supplies and materials are paid at $204.59.~~
~~b) Oxygen supplies are paid at $40.07.~~
~~c) Post-anesthesia observation is paid at $73.41 per 15 minute unit of service up to four hours.~~
~~d) Post-emergency care bed is paid at $28.51 per 15 minute unit of service up to four hours.~~

~~Miscellaneous~~ outpatient hospital facility component charges ~~are paid the lower of:~~

~~(1) submitted charge; or~~

~~(2)~~
- ~~prolonged outpatient IV therapy = $36.63~~
- ~~mental health observation bed = $28.58~~
- ~~external fetal monitoring, four hours or less = $56.27~~
- ~~external fetal monitoring, more than four hours $117.25~~
- ~~end-stage renal disease hemodialysis for outpatient, per treatment = submitted charge (through May 31, 1994)~~

- end-stage renal disease hemodialysis for outpatient, per treatment = is paid in accordance with composite rate methodology for the Medicare program, regardless of service date ~~(as of June 1, 1994)~~.

2.a. Outpatient hospital services. (continued)

Freestanding ambulatory surgical center facility services or facility components are paid in accordance with the methodology in item 6.d.C., Ambulatory surgical centers.

~~The **emergency room facility charge** is paid the lower of:~~

~~(1) submitted charge; or~~
~~(2) (a) provider's cost for a 15 minute unit of services based on a 1983 cost report plus 42.56%; or~~
~~(b) if the provider did not submit a cost report, $35.64 for each 15 minute unit of service.~~

~~The **clinic facility charge** is paid the lower of:~~

~~(1) submitted charge; or~~
~~(2) (a) $35.64 for urgent care facility fee; or~~
~~(b) $25.43 for all other clinic facility fees.~~

Other outpatient hospital services as paid using the same methodology in item 5.a., Physicians' services.

Laboratory services are paid using the same methodology in item 3, Other laboratory and x-ray services.

Vaccines are paid the lower of:

(1) submitted charge; or
(2) the average wholesale price plus $1.50 for administration.

Vaccines available through the Minnesota Vaccines for Children Program pursuant to §1928 of the Act, are paid the lower of:

(1) submitted charge; or
(2) the $8.50 administration fee.

All other injectables are paid the lower of:

(1) submitted charge; or
(2) the average wholesale price.

6.d. Other practitioners' services (continued)

C. **Freestanding ambulatory surgical centers:**

Payment for facility services or facility component is the lower of:

(1) submitted charge; or

(2) (a) Medicare grouper rates; or

(b) if there is not a Medicare grouper rate, payment is at 105.6% of the 1990 average submitted charge; or

(c) if there is not a Medicare grouper rate and there is not a 105.6% of the 1990 average submitted charge, payment is at the State agency established rate, which is derived by backing down the submitted charge to 1990 (by using the CPI) and increasing this amount by 5.6%.